Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROBERT J COOLBAUGH
2318 50TH STREET
LUBBOCK TEXAS 79412

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2579-02

MFDR Date Received

March 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Lubbock Accident and Injury Rehab argues that DWC/MDR DOES have jurisdiction to proceed with an administrative review of a fee reimbursement because this I not compensability issue but simply an incorrect denial from the insurance carrier. We ask that you do not dismiss this request in hopes that TMI will cease with these false and incorrect denials."

Amount in Dispute: $8,306.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Coolbaugh has not remitted payment despite receiving Texas Mutual's denial on March 2, 2011 and being notified by the Division of Workers' Compensation Complaint Resolution section that the health care provider shall remit the payment with interest within 45 days of receipt of the denial. As Dr. Coolbaugh did not timely appeal the refund request, the refunds are now due. Accordingly, Dr. Coolbaugh's request for medical fee dispute resolution should be denied and the Division should order Dr. Coolbaugh to pay the refunds with interest in accordance with §133.260(h)."

Response Submitted by: TEXAS MUTUAL INSURANCE C

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2010 to September 21, 2010	Chronic pain management, office visit, psychiatric diagnostic interview examination, review of a report	$8,306.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.260 sets out the procedure for refunds.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 18, 2010

- 424 – Overpayment recoupment. Current complaints are not related to the injury of 12/08/09 of a bruised coccyx, which has resolved. Requesting recoupment in the amount of $56.90.
- W5 – Request of recoupment for an overpayment made to a health care provider. Promptly remit the refund and a copy of the notification to the address above, attn: Medical Refunds.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration
- W1 – Workers' Compensation State Fee Schedule adjustment
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

Issues

1. Did the requestor meet the requirements of Rule 133.260?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.260 (a), "An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided."
   - The insurance carrier requested a refund on November 18, 2010.
2. Per 28 Texas Administrative Code §133.260 (c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by: (1) paying the requested amount; or (2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment.
   - Dr. Coolbaugh appealed the refund request on January 14, 2011
3. Per 28 Texas Administrative Code §133.260 (e) If the insurance carrier denies the appeal, the health provider: (1) shall remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal; and (2) may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).
   - The requestor did not submit documentation to support that the refund was issued to the insurance carrier prior to filing for medical fee dispute resolution.
4. Review of the submitted documentation finds that that the requestor has not met the requirements of Rule 133.260 and therefore the dispute is not eligible for review by Medical Fee Dispute Resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.